FINAL 11/06

STATE OF LOUISIANA

MEDICATION ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In most instances, medications will be administered by unlicensed personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name _____ Birthdate _____

School _____ Grade _____

Parent or Legal Guardian Name (print): _____

Parent or Legal Guardian Signature:_____ Date:_____

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Relevant Diagnosis(es): _____
2. Student's General Health Status: _____
3. Medication: _____
4. Strength of medication: _____ Dosage (amount to be given): _____

   Check Route: ❑ By mouth ❑ By inhalation ❑ Other _____

   Frequency _____ Time of each dose _____

   _____

   School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.
5. Duration of medication order: ❑ Until end of school term ❑ Other _____
6. Desired Effect: _____
7. Possible side-effects of medication: _____
8. Any contraindications for administering medication: _____

   _____
9. Other medications being taken by student when not at school:

   _____

   _____
10. Next visit is: _____

_____

Prescriber's Name (Printed) Address Phone and Fax Numbers

_____

Prescriber's Signature Credential (i.e., MD, NP, DDS) Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medications orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE.

Inhalants / Emergency Drugs

Release Form for Students to be Allowed to Carry Medication on His/Her Person

Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration training? ❑ Yes ❑ No
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ❑ Yes ❑ No
3. If training has not occurred, may the school nurse conduct a training program? ❑Yes ❑ No

_____

Licensed Provider's Signature Date

VERNON PARISH SCHOOL BOARD
Parent/Guardian's Request & Permission
(THIS SIDE TO BE COMPLETED BY GUARDIAN)

NAME OF STUDENT: _____ **DATE OF BIRTH:** _____

SCHOOL: _____ **GRADE:** _____ **TEACHER:** _____

NAME OF GUARDIAN: _____ **PHONE: (HM)** _____ **(WK)** _____

ADDRESS: _____

ALTERNATE CONTACT: _____ **PHONE: (HM)** _____
(WK) _____

RELATIONSHIP: _____

STUDENT ALLERGIES: **(List medication, food, insects, latex, etc.)** _____

Parent/Guardian Consent

(NEW ORDERS REQUIRED FOR EACH SCHOOL YEAR AND AS ORDERS CHANGE)

I request that the trained school employee give the following:

_____ **To** _____
(Name of medication-One per page) **(Name of Student)**

1. **I agree to provide the medication in a container labeled by the pharmacy specifically for the school time dose.**
2. **I request the school nurse share with the appropriate school personnel, physicians or medical facility, information relative to the prescribed medication administration as the nurse determines necessary for my child's health and safety.**
3. **I understand that I may retrieve the medication from the school at any time and agree that the medication will be destroyed if it is not picked up within two weeks following the termination of the order or one week beyond the end of the current school term.**
4. **I give consent for the school nurse to assess my child in the school setting to assure the safety of giving this medication at school.**
5. **I agree that the initial dose of ordered medicine was/will be given at home and I will observe my child 12 hours for adverse reactions before asking school personnel to administer the medication.**
6. **I agree that I, or a responsible adult, will bring the prescribed medicine to the school to observe and verify the count and receipt of the medication. Up to a 25 day supply can be stored at the school.**

NOTICE: USE THIS BOX ONLY FOR A STUDENT WHO WILL ADMINISTER HIS/HER OWN MEDCIATION, SUCH AS AN INHALER OR EMERGENCY MEDICATIONS. STUDENT WILL BE REQUIRED TO RECORD EACH DOSE AT THE SCHOOL OFFICE.
1. Do you give permission for your son/daughter to self-administer medication of the school nurse determines it is safe and appropriate in the school setting? YES_____ NO_____
2. Do you feel that your child is sufficiently responsible and informed to administer his/her own medication? YES_____ NO_____
3. Do you assume responsibility for your child's actions in his/her self-management of medication at school? YES_____ NO _____

SIGNATURE OF GUARDIAN _____
RELATIONSHIP OF STUDENT _____ **DATE** _____